STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT NEW CASTLE	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint visit was conducted at this facility March 4, 2009 through March 11, 2009. The facility census on the first day of the survey was one-hundred thirteen (113). The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The survey sample totaled twenty-three (23) residents, twenty (20) active and three (3) closed records respectively. There was a subsample of eleven (11) residents for observation and interview that was not included in the sample for complete record review.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Carol D Knowles — Administrator — 5/4/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations and nursing staff interview, it was determined that the facility failed to treat two residents (#SS1, SS#2) out of 23 sampled in a manner that respected, maintained or enhanced their privacy during their personal care. Findings include: 1. Observations of the 203 shower room on 3/5/09 at 7:05 AM revealed Resident SS#1 unclothed in a shower stall with no privacy curtain. This exposed the resident to visualization by anyone entering the shower room. There was no staff in the shower room. A certified nursing assistant (CNA) was observed entering the shower room with towels and wash clothes. Interview with the CNA confirmed that the resident should not have been left uncovered in the shower room. 2. On 03/06/09 at 8:25 AM, Resident SS#2 was observed from the hallway in his room, seated at the foot of his bed unclothed with the exception of an adult brief. The curtains were not fully drawn and the door was open for view to passersby in the hallway. Two staff were noted to be in the room at the time of observation.	F 164	**F164** 1 The shower involving Res #1has had privacy curtain installed. The staff involved with Res #2 have been in-serviced on dignity and privacy of residents. 2 CQI rounds are made by all Dept heads on a daily basis to monitor for similar issues. An audit has been completed on all showers for shower curtains. 3 An in-service will be conducted With each department by the SDC or designee on privacy and dignity of residents 4 The CQI rounds are reported during the morning meeting ,problems are identified, and staff is assigned to follow-up. Social Services Director will audit for the CQI trends and report to the QA team to review and make recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09 4/24/09
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the	F 166		

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F 166	Continued From page 2 facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of facility policies, it was determined that for one resident (#5) out of 23 sampled residents, the facility failed to make prompt efforts to resolve a family's (acting as an agent for the resident) grievance. Findings include: Resident #5 was originally admitted to the facility on 2/7/07 with diagnoses including cerebral artery occlusion, prostate cancer, and progressive supranuclear palsy. Review of social services progress note dated 2/9/09 written by Social Services Staff #1 (SSS #1) documented concerns from Resident #5's family's members which included why the resident has not been seen by an urologist and an oncologist relating to the prostate cancer. In addition, a dermatology consult related the skin condition of resident's bilateral lower legs as well as requesting a change of the attending physician. Review of the facility's policy entitled, "Grievance Protocol - Resident/Family" revealed that their procedure stated that they "Initiate and address all issues and concerns either verbally or in writing on the Resident Concern Report ....and....Document the concern, investigation, resolution and follow-up to the resident concern/grievance." It also stated that they would "Document the concern on the Resident Concern	F 166	**F166** 1. A family meeting was held regarding Res#5 with the NHA and DON on 3/18/09. A follow-up care conference via telephone was held with the son on 3/25/09-no concernes were voiced. 2 The NHA will review March's grievances for timely completion. The Social Service workers will review March's grievances and contact the families and or resident to assure the concern has been followed up and family and/or resident notified. The Social Service Department will meet with resident council determine if there are any unresolved concerns. 3 The NHA will conduct an in-service with Social Services on the grievance policy and the importance of follow up by 4/4/09. The Social Services Dept will conduct in-services with all Departments on the grievance policy. All grievances will be reviewed in the morning department head meeting until resolved. 4 The Director of Social Services will report the grievances and trends completion, timely resolution, and family notification. to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09 4/24/09

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F 166	Continued From page 3 Log." There was no evidence that Resident #5's grievance was documented on the "Resident Concern Report" or the "Resident Concern Log." Although the record review revealed a physician's order dated 2/17/09 which confirmed the change in the physician and that the new physician's progress note was completed on 3/5/09, the record lacked evidence that the family member was informed of this change. Additionally, the record lacked evidence that the additional requests relating to the three specialty care consults were addressed. An interview with Nurse #7 on 3/9/09 at 11 AM revealed that she does recall that the family did request an urology consult, however, was not aware of the requests for the oncologist or the dermatologist. Subsequent to this interview, the attending physician ordered a consult with an urologist, oncologist, and a dermatologist. An interview with SSS #1 on 3/9/09 at 11:30 AM revealed that the above grievances dated 2/9/09 was not followed-up, as required by the facility's policy, thus, the family member was not informed of the facility's efforts to resolve these issues.	F 166	**F252** 1 The stained bathroom floor in Rm 202 is scheduled for replacement. A contract has been signed to replace 17 bathroom floors. Worked is scheduled to start the first week of May and be completed by the end of the month.Room 308 requires frequent visits due to resident behavior issues and is cleaned and checked 2-3 times daily by staff. The facility purchased additional barrels for the soiled linens. 2 An audit of bedside tables will be completed in the resident rooms and shower rooms for stains and offensive odors. Tables in need of replacement will be replaced. Stain and odors will will be followed up by maintence and housekeeping. An order was placed on April 23, 2009 for 35 over bed tables.	
F 252 SS=B	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations of resident rooms during the environmental tour of the facility on 3/4/09	F 252		

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F 252	Continued From page 4 and 3/9/09, it was determined that the facility failed to provide a homelike environment as evidenced by odors detected in resident rooms. Findings include: 1. Observations of resident bathroom 102 on 3/4/09 and bedroom 308 on 3/9/09 revealed an offensive odor in each room. An offensive odor was also detected in the receiving soiled linen area of the laundry room on 3/4/09 at 1:30 PM. 2. An offensive smell in the 203 shower room was detected on 3/4/09 at 11:30 AM. Maintenance and housekeeping staff in the tour called housekeeping staff to get rid of the smell. Additionally, both showers rooms (203 and 502) had an offensive (musty, moldy, sewer type) smell in the room on 3/9/09 at 1:50 PM.	F 252	3 All staff will be in-serviced on reporting Housekeeping and maintence Concerns in the concern log located on each Nursing unit by the SDC or Designee. The log will be checked daily and follow-up will be completed by the maintence and housekeeping departments. CQI rounds are made by department heads on a daily basis to monitor for similar issues. 4 The SDC and the Housekeeping Director will audit the logs for timely follow-up and resolution and report trends to the QA team to review and make recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour with the maintenance and environmental service directors on 3/4/09, and throughout the survey, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior. Findings include: 1. On 3/4/09, debris was observed inside the air conditioner (ac) unit grills in resident rooms 100, 107, 108, 308, and 509.	F 253		

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F 253	Continued From page 5 Additionally, heavy dust was observed in the filter of the air conditioners of room 100, 107, 204, 301, 404, and 506, 2. On 3/4/09, 3/5/09, brown dirt was observed on geri chairs, wheelchairs or pads on chairs belonging to residents in room 102A, 106B, 402A, 403A, 604B, and an unidentified wheelchair in the 600 unit hallway. After bringing the dirt to the attention of the facility on 3/4/09 at 11:15 AM, one certified nursing assistant was observed assisting one resident to sit in the dirty geri chair when the maintenance staff on the tour directed the staff to clean it first. 3. On 3/4/09 at 9:45 AM, corroded commodes were observed in resident bathrooms 306, 611 and the 502 shower room. 4. On 3/4/09 and 3/9/09, stained and/or cracked bathroom floors of resident rooms 100, 102, 107, 108, 204, 207, 210, 300, 301, 306, 400, 402, 406, 506, 509, 602, and 610 were observed. Additionally, the caulking around the toilet rim in resident rooms 102, 107, 203 shower room, and 406 were in disrepair. 5. On 3/4/09, dirty privacy curtains were observed in resident rooms 108A, 306A, 610A, and two (2) of seven (7) curtains in the 502 shower room. 6. On 3/4/09, dirty trash can external surfaces were observed in resident rooms 210, 303, 306, 506, 509, 602, and the activity room. Additionally, liners or plastic bags were missing from trash cans in resident rooms 204, 301, 603. 7. On 3/4/09, 3/5/09, and 3/9/09, dirty hoyer lift	F 253	**F253** 1. All A/C grills and filters, hoyer lifts, geri-chairs, wheelchairs, commodes, and resident personal belongings have been cleaned. Bids are being obtained to repair/replace damaged bathroom floors in specified resident rooms. Caulking issues have been completed. Dirty privacy curtains in shower room have been replaced. External surfaces of specified trash cans have been cleaned and bags supplied. replacements for damaged over the bed tables have been ordered. damaged walls and wallpaper are scheduled for repair. Plaster has been painted, wobbly tables have been stabilized. Baseboard and trim in storage area by dining room has been replaced. Janitor closets have been repaired. A contract has been signed for installation of 17 bathroom floors. Installation is scheduled to start the first week of May and tentative completion prior to the end of the month. 2. An audit of bedside tables will be completed to determine their condition and replaced as needed. An order has been placed for 35 over bed tables on April 23, 2009. The Maintenance department will complete monthly preventative maintenance rounds.	

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F 253	Continued From page 6 platforms were observed on the hallways outside room 105, 107, 310, and 509. 8. On 3/4/09 and 3/9/09, stained over-the-bed table surfaces in the occupational therapy room, resident rooms 311, 308 A, and 308B were observed. 9. Throughout the survey, scratched walls (or wallpaper) were observed in resident rooms 108, 210, 300, 306, 402, 406, 509, the hallway wall outside room 402, the 300 unit hallway, the 600 unit hallway, the physical therapy hallway, and the entrance visitor bathroom hallway. One resident interviewed revealed the scratch on the wall was present in his room at the time he moved into the room. Additionally, unpainted plaster was observed in resident room 204. 10. On 3/4/09 at 1:20 PM, unstable or wobbly tables were observed in the main dining room (10 of 12) and the activity room (4 of 4). On 3/5/09, interviews with one resident revealed the tables were wobbly and she did not like the table to be wobbly. On 3/11/09 during the exit with the residents, a resident stated the tables were wobbly and unsafe. 11. On 3/4/09, the wall baseboard trim or molding of the kitchen food cart storage area next to the dining room, the 100 unit janitor closet with a hole on the wall, and the 400 unit janitor closet were in disrepair.	F 253	3. ESD has completed in-service with housekeeping staff on how to properly clean and maintain equipment and the need to have supplies available for use at all times. Housekeeping concern logs have been implemented on each nursing unit. The EDS and Maintenance Director will conduct weekly audits on compliance. CQI rounds have been updated to include audit of privacy curtains and supplies to be monitored on a daily basis. Staff will be in-serviced by SDC on how to report maintenance and housekeeping issues. 4. At the monthly QA meeting, the housekeeping director and EDS will report results on the audits of logs for resolution of issues. The BOM or designee will audit problems found on CQI rounds and report on resolution of issues identified Results of audits will be reviewed for recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 309	Continued From page 7 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to provide care and services according to the plan of care for six (6) residents (Residents #2, #8, #11, SS#4, SS#5 and SS#8) out of 23 sampled residents. Five residents did not receive medications and/or supplements as ordered and one resident did not have a laboratory test performed. Three of six examples had failures pertaining to system failures of recapitulation of orders or not identifying orders correctly in the 24 hour check. Findings include: 1. On 2/4/09 at 12 noon Resident #8 was ordered an antibiotic Polytrim eye drops four times a day (qid) to treat an eye infection. The antibiotic was not delivered and not administered until 2 PM on 2/5/09, over 24 hours later. There was no evidence that the facility contacted the pharmacy on 2/4/09 3 PM to 11 PM shift or 2/5/09 11 PM to 7 AM shift when the antibiotic did not arrive at the regularly scheduled deliveries. According to staff the pharmacy delivers around 3 PM and 4 AM daily. An interview with three nursing staff (Nurse #7, 8 and 9) on 3/9/09 revealed that if an antibiotic was not in the interim box it should be ordered stat or from the back up pharmacy and received within four hours. This particular antibiotic was not available in the interim box. It was further revealed that this antibiotic was on back order	F 309	**F309** A. Res #8 eye drops have been received from pharmacy. Res #2 pro source order obtained and started, Res #11 UA was d/c'd, Res SS #4 multi vitamin was started, and Res #9 antibiotic was obtained. The physician was notified. B. The pharmacy completed a MAR to cart audit in March. The pharmacy reviewed the POS for orders that were not carried forward from one month to the next and any errors have been corrected. C. In-services are being completed by the Pharmacy and DON on the procedure to complete a recapitulation. The DON in-serviced 11-7 nurses On chart check procedures. D. A random audit of three residents on each Hall will be completed on the first of each New month by the DON and ADON for Accuracy. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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F 309	Continued From page 8 from the pharmacy which added to the delay. Staff also stated that they did not contact the doctor about the delay because the pharmacy kept telling staff that they would get it soon. A nurse's note documented that on 2/5/09 7 AM to 3 PM shift staff made four calls to the pharmacy before finally reaching someone who would ensure the delivery of the antibiotic. 2. Resident #11 had a physician's order dated 1/29/09 for an urinalysis and an urine culture and sensitivity due to agitation. Record review lacked evidence that the above order was completed. An interview with Nurse #5 on 3/5/09 at 1 PM confirmed that the facility failed to obtain the urine specimen for the above testing, thus, failed to complete the above order. 3. Resident SS#4 was observed during a medication pass on 03/05/09. Upon reconciliation following the pass, it was determined that a physician's order for a multivitamin (MVI) was ordered on 12/01/08. A review of the Medication Administration Record (MARs) for March 2009 did not indicate the MVI had been administered for all days in the month. Previous MARs including February 2009 indicated that the MVI had been administered. A further review of the Physician's Order Sheets (POS) did not indicate the MVI had been discontinued. The Unit Manager (Nurse #5) stated on 03/05/09 that the MVI had not been carried over to the POS for March and that the facility failed to administer the MVI according to physician's orders.	F 309		

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F 309	Continued From page 9 4. During a medication pass on 03/05/09, Resident SS#8 was observed and compliant with administration of medications including the supplement, Prosource. Upon reconciliation following the pass, it was determined that the current POS for March 2009 stated Prosource 30ml in 120ml in water twice daily. A review of the previous months POS's reflected the same. A review of the March 2009 medication administration record stated Prosource four times daily and was administered as documented. Although Dietitian notes indicated the recommendation of Prosource four times daily on 10/21/08, the recommendation was not acknowledged by the physician and not incorporated into the plan of care at the time of exit. This finding was confirmed with Nurse #6 on 03/09/08 at 10:05 AM. 5. During a medication pass on 03/06/09, Resident SS#5 was observed and compliant with the administration of medications, including a Cranberry capsule 300 mg. by Nurse #3. Upon reconciliation following the pass, it was revealed that the physician's order dated 01/16/09 was for Cranberry capsule 475 mg daily. A review of the March MARs stated Cranberry capsule 475 mg. During an interview with Nurse #3 on 03/06/09 it was discovered and confirmed that the bottle of Cranberry capsules for Resident SS#5 delivered from the pharmacy was 300mg. instead of 475 mg. The nurse failed to notice the discrepancy when administering the medication. 6. Resident #2 had a physician's order, dated 1/13/09, to receive ProSource (protein supplement) twice a day. The MAR stated that the resident had received the ProSource from	F 309		

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F 309	Continued From page 10 1/14/09 through 1/31/09. Review of the clinical record revealed that the ProSource order did not appear on the 2/09 MAR and monthly POS and the facility failed to carry over the order during the monthly recapitulation. Resident #2 failed to receive the ProSource from 2/1/09 through 3/9/09, a total of 74 doses. Interview with the facility's Registered Dietitian (RD)on 3/10/09 confirmed that the ProSource had not been discontinued and the resident should have continued to receive it.	F 309		
F 313 SS=D	483.25(b) VISION AND HEARING To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that one (#5) out of 23 sampled residents received the proper assistive device to maintain vision abilities. Findings include: Record review revealed an interim physician's order dated 12/6/08 for the resident to have prism glasses to increase visibility during meals as requested by the speech language pathologist (SLP).	F 313	**F313** A. Res #5 prism glasses are kept In the med cart except during Meals. The C.N.A. brings the Resident to the nurse who puts The glasses on the resident prior To going into the dining room. The C.N.A. returns the resident To the nurse after the meal and the Glasses are returned to the cart. This process has been added to the C.N.A. care delivery guide. B. An audit of adaptive devices for meals will completed to ensure the residents have the devices they need.	4/24/09

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F 313	Continued From page 11 Review of the monthly POS's for January 2009, February 2009 and March 2009 revealed that during the monthly recapitulation process, the facility failed to carryover the order for the prism glasses. Review of the CNA "Care Delivery Guide" failed to document the prism glasses to be worn during meals. During lunch observation on 3/4/09 at 11:50 AM, Resident #5 had a pair of glasses with the right ear piece missing and not the prism glasses as ordered. Interview with the ordering SLP during the survey confirmed that the resident was ordered the prism glasses during meals. Findings reviewed during the exit on 3/11/09 with administration.	F 313	C. The staff will be in-serviced by the SDC and or Designee to check meal ticket for adaptive equipment. The dietician will complete random audits on adaptive equipment to ensure it is available at meals. Corrections will be made immediately if any such equipment is not available. D. The Dietician will report the results of the audits to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview, it was determined that the facility failed to maintain an environment free from accident hazards. The hand sink hot water temperature in three resident	F 323		

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F 323	Continued From page 12 rooms was above the safe and normal range of 110 degrees Fahrenheit. A treatment cart and a janitor closet (with hazardous chemicals) were found unlocked and accessible to residents. A commode in a shower room and space between the mattresses and the foot of the bed were unsafe. Two residents (SS# 3 and SS# 9) were observed in the hair salon with oxygen via nasal cannula attached to oxygen cylinders. Findings include: 1. On 3/4/09 at 11:15 AM, the hand sink hot water temperatures of resident room 107, 102, and 211 were 114.4 degrees Fahrenheit (F), 115.3 Fahrenheit (F), and 115.3 Fahrenheit (F) respectively. 2. On 3/4/09 at 10:00 AM, a treatment cart on the 500 unit of the facility outside room 506 was observed unlocked and unattended and accessible to residents. Staff interview confirmed this finding. 3. On 3/9/09 at 9:25 AM, the 400 unit janitor closet with hazardous chemicals was observed unlocked . A nursing staff stated she would check to see if the room needed to be locked but did not return to inform the surveyor of her findings. Maintenance staff interview revealed the janitor closet needed to be locked at all times. 4. On 3/5/09 at 7:35 AM, a commode in the common shower room 502 was on top of the toilet but all the four legs were not touching the floor. This is an accident hazard.. Interview with a nursing staff revealed that the legs should be touching the floor and she did not know why the commode was left that way.	F 323	**F323** 1. Hot water valve was adjusted to correct temperature. Treatment cart on 500 hall immediately locked. Janitors closet in 400 hall corrected, commodes legs immediately adjusted to correct level, mattress extensions were placed on mattresses in specified rooms and oxygen tank was removed from beauty shop immediately. 2. An audit was completed on the gap Between the mattress and headboards On all beds. Bolsters have been supplied. The staff and residents have been In-serviced on the oxygen not being Utilized in the beauty shop . All housekeeping Carts were checked for locked chemicals. 3 . The housekeeping department will be in-serviced by the ESD on the need for locking up chemicals in the closet and on carts. The facility staff and residents will be inserviced on the need for proper use and storage of oxygen equipment. Maintenance department will be in-serviced by the NHA about maintaining the water temperature between 100 and 110 degrees. The maintenance department will conduct daily audits on the water temperature and maintain a log. Nursing staff will be inservied on locking med and treatment carts.	4/24/09

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F 323	Continued From page 13 5. On 3/4/09 at 11:35 AM, a gap of over 6 inches in the bed of resident room 207 was observed between the mattress and footboard. Interview with the maintenance director revealed the mattress was 75 inches and the bed was 84 inches. Additionally, on 3/9/08 at 9:10 AM, a gap of six inches was observed between the mattress and the footboard bed frame of resident room 308B. 6. On 3/11/09 at 10:30 AM, Residents SS# 3 and SS# 9 were observed in the hair salon having their hair groomed. Both of the residents were receiving oxygen through their nares using a nasal cannula which was attached to the oxygen cylinder.	F 323	4. Random audits will be conducted weekly By the unit managers for unlocked Treatment and med carts. The DON will report the results of the audits on the locked treatment and med carts, the maintenance director will report the water temperature log, and the HousekeepingDirector will report on the audits on the proper storage of chemicals. All audits will be reported to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that two (#8 and #14) out of 23 sampled residents received enteral feedings as ordered by the physician. The facility also failed to ensure the	F 328		

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F 328	Continued From page 14 oxygen concentrator units were properly maintained. Findings include: 1. Resident #8 had diagnoses which included dementia, hypertension, coronary artery disease, and advanced breast cancer. The resident was readmitted on 12/22/08 with a tube feeding for nourishment. Resident #8 had a change in tube feeding orders on 1/2/09 that stated Isosource 1.5 @65 cc/hr x 20 hours. However, the administration record indicated the formula was to be started at 2 PM and discontinued at 8 AM daily which was only 18 hours. The formula was changed to Osmolite 1.5 on 1/30/09 for 20 hours and again scheduled for only 18 hours. This continued until 2/24/09 when the corporate dietitian discovered the error and changed the start time to 12 noon to complete the full 20 hours of formula intake. An interview with the unit manager on 3/10/09 revealed that the corporate dietitian identified the timing discrepancy during a visit to the facility. The resident did not develop a significant weight loss despite the fact the resident was also experiencing a decline in health status. 2. Resident #14 had diagnoses which included stroke, dementia, chronic renal insufficiency and coronary artery disease. The resident had a feeding tube for nourishment and was receiving Hospice services. Tube feeding orders, dated 11/10/08 stated the resident was to receive Isosource 1.5 @ 60 cc/hr x 20 hours. However, the administration record from 11/11/08 through	F 328	**F328** 1. Res #8 order was corrected on March 3, 2009. All affected concentrator Filters were replaced. Res #14 Tube feeding order was corrected on March 3, 2009 2. The corporate dietician completed an audit of all of the residents on tube feedings for accuracy of physicians orders on March 3, 2009. An audit was completed on all concentrators for clean filters and replaced as needed. 3. An in-service will be conducted by SDC withnursing staff on enteral feedings policy and procedure. The DON will inservice 11-7 staff on proper procedure of cleaningreplacing filters. 4. The Dietician will audit all residents admitted with tube feeing orders and any new orders for enteral feedings to ensure that the resident is receiving the prescribed nutrition. Dietician will report findings to QA team. 11-7 supervisor will be conducting random audits for compliance with replacement of filters and the DON will report results of audit to the Q.A. Team. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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F 328	Continued From page 15 2/6/09 indicated the formula was to be started at 8 PM and discontinued at 2 PM daily, 18 hours instead of the 20 hours ordered. The formula was changed to Osmolite 1.5 @ 60 cc/hr x 20 hours on 2/7/09 and again was scheduled for only 18 hours. This continued until 2/26/09 when a corporate dietitian noted the timing error and changed the stop time to 4 PM daily to ensure 20 hours of feedings. Interview with the southside unit manager on 3/10/09 revealed that the issue had already been identified by the facility. Resident #14 maintained his usual body weight range noted prior to his readmission from the hospital. 3. During the environmental tour on 3/4/09 at 12:15 PM, the filter was missing from resident room 306A's oxygen concentrator. The resident was observed lying on her bed using the concentrator unit at the time. 4. On 3/4/09 at 11:55 AM revealed Resident #8's two filters on the oxygen concentrator were heavily coated with dust and lint. The resident was using the oxygen at the time of the observation. 5. During the entrance tour on 3/4/09 between 8:30 AM to 9:10 AM, oxygen concentrator filters for Residents SS #10 and SS #11 were observed with debris. 6. On 3/10/09 at 11 AM, Resident SS #9's oxygen concentrator filters were observed with thick, built-up debris.	F 328		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 16 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (#14) out of 23 residents sampled drug regimen was adequately monitored. The facility failed to ensure that Resident #14's blood level for Valproic Acid (Depakote-anticonvulsant) was monitored during administration of the medication to detect potential adverse consequences. Findings include: Cross refer F428, example #2	F 329	**F329** A. Res #14 has had a depakote blood level drawn. The depakote levels were in normal limits. MD informed of lab results. B. An audit is going to be completed on resident medications that require blood level monitoring. C. In-service nurses on which medications need blood level monitoring by the staff education director. Residents on medications that need blood level monitoring will have blood levels drawn q 6 months and they will be reviewed monthly by the unit managers. D. The DON will report the results of the audits to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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F 329	Continued From page 17 Resident #14 was readmitted to the facility on 11/10/08 post hospitalization for replacement of a feeding tube and had diagnoses that included cerebral vascular accident (stroke), dementia and depression. Readmission orders , dated 11/10/08, included an order for the resident to receive Depakote, an anticonvulsant sometimes used for behavior disorders which requires monitoring of blood levels to ensure it is within therapeutic range. The 11/10/08 readmission orders failed to include orders for Depakote levels to be drawn. Review of Resident #14's clinical record revealed that the resident had been on Depakote prior to his hospitalization and that the last Valproic Acid level had been drawn on 6/9/08. The 9/08 physician's order sheet indicated that Depakote levels were to be drawn every 6 months. On 3/9/09 the facility's Unit Clerk was asked to call the laboratory to determine if a Valproic Acid level had been drawn in 12/08 or anytime after. The Unit Clerk stated that the laboratory had no record of the level having been drawn.	F 329		
F 333 SS=E	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two (#13 and #16) out of 23 sampled residents were free of significant medication errors. Findings include:	F 333		

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F 333	Continued From page 18 Cross refer F428, example #3 1. Resident #16 had a physician's order, dated 2/23/09 to discontinue Flomax (used to treat signs and symptoms of benign prostatic hyperplasia). Review of the 3/09 medication administration record (MAR) and monthly physician order sheet revealed that when the monthly recapitulation was done, the facility failed to carry over the order to discontinue the Flomax. The MAR from 3/1/09 through 3/9/09 indicated that the resident received the Flomax, a total of nine (9) doses, despite it's being discontinued on 2/23/09. Findings were confirmed with Nurse #5 and the Flomax was discontinued. 2. Resident #13 had a physician's order dated 1/29/09 for Aricept (medication to treat Alzheimer's type of dementia) 5 mg. daily through the PEG (percutaneous endoscopic gastrostomy, a tube placed in the stomach for feeding and/or for administering medication) daily. Review of the MAR for January 30, 2009 and January 31, 2009 lacked evidence that the above medication was initiated as ordered. Additionally, review of the February 2009 and March 2009 monthly physician's order sheet revealed that the facility failed, during the monthly recapitulation process to carry over the above order for the Aricept, thus, the resident did not receive the medication as prescribed on 1/29/09 for period of 35 days. An interview with Nurse # 5 on 3/5/09 at 2:30 PM confirmed that Aricept order was not administered as ordered. Subsequently, on 3/5/09, the facility obtained an order to discontinue the medication.	F 333	**F333** A. Res #13 and #16 all orders were corrected. The physician was notified. The residents have been reassessed for the appropriate utilization of the medication by the physician. B. The pharmacy completed a MAR to cart audit in March. The pharmacy reviewed the POS for orders that were not carried forward from one month to the next. All errors have been corrected. C. In-services are being completed by the pharmacy and DON on how to complete a recap. The DON has in-serviced the 11-7 nurses on chart check procedures. A random audit of 3 residents on each hall will be completed on the first of the month by the DON and ADON for accuracy of the recaps. D. The DON will report the results of the audits to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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F 333	Continued From page 19 An interview with the prescribing provider on 3/9/09 at 2 PM revealed that she was made aware of the above medication not being initiated during the survey and that the provider plans to reassess the resident's cognitive impairment.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (#8, SS#5) out of 23 sampled residents the facility failed to ensure the timely and accurate acquiring of medication from the contract pharmacy. Findings include: 1. Cross refer F309 example #1.	F 425	**F425** A. Res #8 received eye drops and Resident #5 who had the order for cranberry caps has been corrected. Physician notified of pharmacy service issues. B. The pharmacy completed a MAR to cart audit in March. The pharmacy reviewed the POS for orders that were not carried forward from one month to the next. All errors have been corrected. C. In-services are being completed by the pharmacy and DON on how to complete a recap. The DON has in-serviced the 11-7 nurses on chart check procedures. A random audit of 3 residents on each hall will be completed on the first of the month by the DON and ADON for accuracy of the recaps. D. The DON will report the results of the audits to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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F 425	Continued From page 20 Resident #8 waited over 24 hours to receive an antibiotic eye drop, ordered to be given four times a day, from the pharmacy. The pharmacy failed to utilize their back up pharmacy in a timely manner when they did not have the ordered antibiotic available. 2. Cross refer F309 example #5. Resident SS#5 had a physician's order for Cranberry capsules 475 mg daily and the pharmacy incorrectly sent 300 mg tablets.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that during the monthly drug regimen review, the licensed pharmacist failed to identify and report irregularities for six (#2, #14, #16, #13, #11 and # 19) of 23 sampled residents. Findings include: 1. Resident #2 had an order, dated 12/08/09 to receive Tramadol HCl (analgesic) 25 mg by mouth four times a day. The monthly physician order sheets (POS) and medication administration records (MAR) from 1/09 through 3/09 stated, "Tramadol HCl 50 mg tablet 1/2 tab	F 428		

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F 428	Continued From page 21 (50 mg) by mouth four times a day." Review of the clinical record revealed that a monthly drug regimen review was completed on 1/7/09 and 2/3/09 which failed to identify the transcription error of 50 mg instead of 25 mg. On 3/5/09 at 1:35 PM the facility's pharmacy consultant was completing Resident #2's monthly drug regimen review. She confirmed that a transcription error had occurred and would be corrected. Cross refer F329 2. Review of Resident #14's clinical record revealed that monthly drug regimen reviews were completed from 6/08 through 3/09. The 7/1/08 Medication Regimen Review indicated that a Valproic Acid level had been obtained. The monthly drug regimen review from 12/08 through 3/09 lacked evidence that the licensed pharmacist identified and reported the lack of Valproic Acid level monitoring, last completed six (6) months earlier. Cross refer F333, example #1 3. Resident #16 had a physician's order, dated 2/23/09 for Flomax to be discontinued. Review of the Medication Regimen Review sheet indicated that a licensed pharmacist had completed a review on 3/5/09 and noted "Discontinue Flomax." Despite the monthly drug review having been completed on 3/5/09, the licensed pharmacist failed to identify that the 3/09 POS and MAR noted the Flomax order as being active and that nursing staff were administering it erroneously. Resident #16 received Flomax from 3/1/09 through 3/9/09.	F 428	**F428** A. Physicians caring for the identified residents were notified and the following action was taken: Transcription error for Res # 2 was corrected. Resident #14 obtained a depakote level. Res #16 medication was discontinued. Res #11 medication error was corrected and the route of administration was changed. Res #19 route of administration was changed. B. The pharmacy completed a drug regimen audit for each resident on April 1,2,3, 2009. The NHA and DON met with the Pharmacist to discuss the facilities concerns about pharmacy services on April 1. The pharmacy has implemented an internal quality assurance focus on the service which they provide Arbors. C. NHA and DON met with Pharmacy on 4/3/09 to discuss her findings and the importance of accurate reporting. the pharmacy will be sending a Representative to the monthly QA meetings D. The Pharmacy representative will Report findings to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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	085039	A. BUILDING _____ B. WING _____	C 03/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT NEW CASTLE	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 22 Cross refer F333, example #2 4. Resident #13 had a physician's order dated 1/29/09 for Aricept 5 mg. through the PEG daily. Review of the Medication Regimen Review (MRR) sheet indicated that a licensed pharmacist had completed the monthly review in February 2009, however, failed to identify that the order was not on the February monthly POS and that the resident was not receiving this medication. 5. Resident #11's monthly POS for February 2009 and March 2009 included medications of Norvasc 5 mg. daily and Lasix 10 mg.daily to be administered orally. In addition, both of these medications were transcribed on the February 2009 and March 2009 MAR as medications to be given by mouth and the staff nurses were consistently documenting that these were administered orally. Interviews with the above staff nurses during the survey revealed that the nurses were incorrectly documenting that the medications were being administered by mouth. Rather, the above medications were being administered through the Resident #11's PEG. Although the February 2009 MRR indicated that a licensed pharmacist had completed the review, the pharmacist failed to identify that the resident did not take anything by mouth and that the order contained the incorrect route of administration. Subsequent to the surveyor's inquiry, on 3/5/09, Nurse #5 obtained an order for NPO (nothing by mouth). 6. Resident #19's monthly POS for February 2009 and March 2009 included Aricept 5 mg. daily to	F 428		

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F 428	Continued From page 23 be administered orally which was transcribed on the February 2009 and March 2009 MAR as medications to be given by mouth. The staff nurses were consistently documenting that the medication was being administered orally. Interviews with the above staff nurses during the survey revealed that the nurses were incorrectly documenting that the medications were being administered by mouth. Rather, the above medications were being administered through the Resident #19's PEG. Although the monthly MRR for February 2009 indicated that a licensed pharmacist had completed the review, the pharmacist failed to identify that the resident did not take anything by mouth and that the order contained the incorrect route of administration. Subsequent to the surveyor's inquiry on 3/9/09 at 3 PM, Nurse #7 obtained an order for NPO for Resident #19.	F 428		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced	F 441		

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F 441	Continued From page 24 by: Based on facility documentation, staff interview, and review of the facility's tuberculosis screening policy, it was determined that the facility failed to conduct complete tuberculosis screenings on 13 out of 24 sampled staff. Additionally, staff did not clean blood properly in one resident room. Findings include: 1. Employees #1 through #10 were hired between 8/4/08 and 1/7/09. There was no documentation that the second step of a two-step tuberculin (PPD) test was conducted upon hire of the staff. There was also no record on file that the staff had a prior tuberculin (PPD) test prior to work at this facility. 2. Employee #11 with hire date of 2/18/09 had no tuberculin (PPD) test result data on file. 3. Employee #12 with date of hire of 4/28/08 had the first step given 4/2/09 and the second step given 9/9/08 or four months later. 4. Employee #13 with date of hire of 12/17/08 had stated and record showed the staff had a positive PPD test yet the x-ray was missing from the staff file. An interview with the Human Resources manager on 3/5/09 at 10:00 AM confirmed the findings. According to the facility's infection control policy and procedure, a two-step Mantoux (Purified Protein Derivative, PPD) TB skin test would be administered to all new employees and volunteers that do not have documented proof of a negative Mantoux test. The procedures also stated to "obtain a chest x-ray and a medical evaluation if the employee experiences a positive	F 441	**F441** 1. Employee PPD's have been completed. Employee chest x-ray results have be obtained and Room 311 has been properly disinfected. 2. An audit was completed on all personnel files to identify any other staff members that have not had two step ppd's. 3. . NHA will in-service SDC on regulations requiring two step ppd completion on all staff. An audit will be completed by the SDC on all new hires and the anniversary dates of current staff and the status of their ppd's. All employee's needing PPD will receive the test. The SDC will complete an in-service on how to clean a blood spill properly. Infection control rounds will be conducted weekly by the ADON. 4. The SDC will conduct monthly audits and report findings of the status of employee PPD's to the QA team for review and recommendations. The ADON will conduct and report results of infection controlrounds to the QA team for review and recommendations. QA will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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F 441	Continued From page 25 reaction to the current skin test with a reaction greater than or equal to 10mm. 6. During the environmental tour with maintenance and housekeeping staff on 3/4/09 at 12:15 PM, dried blood was observed on the floor of resident room 311 while the two residents were in the room. An interview with a certified nursing (CNA) staff revealed she had cut herself earlier and she missed cleaning some area of the floor. She was then observed taking a few paper towels, wetting them, and cleaning the blood off the floor without gloves. Interview with maintenance staff revealed the staff should not have left the resident room without cleaning the blood completely, should have requested a kit to clean the remaining blood, should have worn gloves even if it was her own blood, and should have requested housekeeping staff to disinfect the floor.	F 441	**F444** A. No specific resident was identified. The nurse was in-serviced on proper hand washing when administering medication. B. All residents have the potential for risk. C. SDC and or Designee will in-service the nursing staff on proper hand washing and preventing the spread of infection. The ADON will conduct random infection control surveillance rounds. D. The ADON will report results of the random infection control surveillance rounds to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility staff failed to use appropriate handwashing technique to prevent the spread of infection from one resident to another. Findings include: 1. On 03/06/09 during a routine medication pass, Nurse #1 passed medication to three (3) residents. Following each medication pass,	F 444		

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F 444	Continued From page 26 Nurse #1 was observed performing hand washing. On all three (3) occasions, Nurse #1 was observed turning off the faucet with bare hands. 2. On 03/06/09 during a routine medication pass, Nurse #2 passed medication to three (3) residents. Following each medication pass, Nurse #2 was observed performing hand washing. On all three (3) occasions, Nurse #2 was observed turning off the faucet with bare hands.	F 444		
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that the facility failed to provide a sanitary and safe environment for the residents, staff and visitors. Findings include: 1. On 3/4/09 at 10:20 AM, an uncovered trash barrel was observed in the 500 soiled utility room. Paper towels were missing from this room near the hand sink. On 3/4/09 at 11:25 AM, an uncovered trash barrel and an uncovered and overfilled biohazard barrel were observed on the 200 soiled utility room. 2. Observation of the kitchen walk-in freezer on 3/4/09 at 9:00 AM revealed frost on the floor of the freezer. A large chunk of ice was observed on the floor. This is a safety hazard for the dietary	F 465		

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F 465	Continued From page 27 staff. Additionally, the metal plate in the bottom of the walk-in refrigerator was protruding out of the frame which can also be a hazard for the staff. 3. Throughout survey, the dining room floor edges along the floor had encrusted dirt on them. On 3/4/09, a dirty wall outside the hallway of the 300 unit, and a dirty wall behind the toilet of dietary staff bathroom in the kitchen were observed. The front visitor bathroom floors (and hand sink top counters) were dirty. 4. Dirty cleaning cart yellow buckets outside room 106, 402 were observed. 5. Personal care items were observed unlabelled, accessible to residents as follows: a. In the shower stalls of the 502 shower room personal care items such as a Sensatec alarm unit (belonging to a resident), a McKesson shaving cream can, a Provon moisturizer, a personal cleanser, a moisturizer belonging to resident in room 600 on 3/4/09 at 10:20 AM. b. In an unlocked cart inside the 203 common resident shower room personal items such as one hair brush and toothbrush belonging to residents on 3/4/09 at 11:30 AM. c. On the 300 and 306 resident shared bathroom hand sink counter personal items such as Listerine mouth wash, a toothbrush, toothbrush in a case without a name, a pink denture storage container, a dial deodorant on 3/4/09 at 12:05 PM. d. On the 107 and 406 resident shared handsink counter personal items such as an unlabelled	F 465	**F465** 1. Trash barrels on 500 hall and In soiled utility room were immediately covered. Paper towels were filled, 200 hall trash barrel and bio hazard bins emptied. Frost and ice was removed from walk in freezer. Dining room floor, walls and sinks have been cleaned. all housekeeping equipment has been cleaned and resident's personal care items that are not marked have been disposed of. 2. CQI rounds were made by department heads to monitor for storage of trash, full bio hazard bins, full trash cans, and cleanliness of floors and walls. The food service director monitors for frost and ice in freezer. 3. SDC and or Designee will in-service the staff on maintaining a safe clean environment. The CQI tool has been updated to include all deficient areas rounds are conducted M-F and results will now be reported in the morning meeting for correction and follow-up by department heads. 4 The Social Services Director or designee Will report the results of the CQI trends to the QA team to review and make recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

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F 465	Continued From page 28 container of Provon shampoo, a hair brush, two Provon cream bottles, two perineal cleansers, and a spice deodorant container were observed on top of a shared hand sink of resident room on 3/4/09 at 11:15 AM. Staff interviews confirmed these findings.	F 465		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (#9) out of 23 sampled residents were provided with laboratory services in a timely manner. Findings include: On 12/11/08 Resident #9 was treated with Kayexalate (medication that helps reduce potassium in the body) for an elevated potassium level of 6.1. On 12/12/08 at 9:25 AM the physician ordered a basic metabolic profile to be done due to elevated potassium. On 12/13/08 nurses notes stated that the lab missed the lab slip in the book and did not obtain bloodwork. The note went on to reveal that several calls had been made to the laboratory with no response. The nurses notes further revealed that the lab came in again on 12/14/08 and missed drawing the bloodwork again. The staff obtained an order from the physician to get the lab work done stat and the laboratory staff	F 502	**F502** A. Res #9 lab was obtained. The Lab results were within normal Limits. The MD was notified of the lab results. B. The lab requisition book will be audited for the month of March to identify any resident with the potential for risk. C. The lab requisition books will be reviewed during the daily clinical meeting. Orders will be verified that they are scheduled and the book will be monitored for timely results. The nursing staff will be in-serviced on the lab policy and procedure. The DON and ADON will conduct random audits on 5 residents on each unit. D. The DON and or ADON will report the results of the CQI trends to the QA team to review and make recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.	4/24/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 502	Continued From page 29 returned to the facility and obtained the blood work. The resident's potassium was 6.9 and he was admitted to the hospital for treatment.	F 502		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085039	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 3/11/2009
NAME OF PROVIDER OR SUPPLIER ARBORS AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 32 BUENA VISTA DRIVE NEW CASTLE, DE		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 258	483.15(h)(7) ENVIRONMENT- SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that the facility failed to ensure comfortable sound levels. Findings include: 1. On 3/4/09 at 11:30 AM, the TV of resident room 103 was blasting with sound that was uncomfortable. Interview with a resident in the proximity of this TV confirmed it was too loud and it was like that all the time.

F258

1. Room 103 TV was turned down.

2. An audit has been conducted on each shift for loud televisions. Residents and families have been reminded of other resident's rights, headphones have been suggested to some residents.

3. The SDC will in-service staff on proper noise levels in the building, resident's rights and times to turning down the TV's. If a resident is in need of head phones the Social Services department will work with the resident and their family to obtain them. The Unit Manager will conduct random rounds to monitor the noise level.

4/24/09

4. The Director of Social Services do random audits on noise levels and will report the noise level audits to the QA team for review and recommendations. The QA team will monitor for 3 months or until 100% compliance is achieved.

4/24/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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STATE SURVEY REPORT

NAME OF FACILITY: Arbors at New Castle

DATE SURVEY COMPLETED: 3-11-09

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint visit was conducted at this facility March 4, 2009 through March 11, 2009. The facility census on the first day of the survey was one-hundred thirteen (113). The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The survey sample totaled twenty-three (23) residents, twenty (20) active and three (3) closed records respectively. There was a subsample of eleven (11) residents for observation and interview that was not in the sample for complete record review. 3201 Delaware Regulations for Skilled and Intermediate Care Nursing Facilities	
3201.6.0	Services to Residents:	
3201.6.1	General Services:	

Provider's Signature David Shoulder Title Administrator Date 5/12/09

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 3/11/09, F309, F313, F323 examples #2 and #4 through #6, F328, F329, F425, F428, F441 example #6, F444 and F502.	Please cross reference with f-309, 313, 323,328, f329, 425, 428, 441 444 502. in the Federal 2567 for clarification
3201.6.9	Housekeeping and Laundry Services:	
3201.6.9.1	The facility shall employ sufficient housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey report date completed 3/11/09, F252, F253, F465.	Please cross reference Ftag 252, 253 and 465 in the Federal 2567 For clarification

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.11	Medications	
3201.6.11.1	Medication Administration	Resident # 13 and #16 all orders were corrected. The pharmacy completed a MAR to cart audit in March. The pharmacy reviewed the POS for orders that were not carried forward from one month to the next. All error have been corrected. In-services are being completed by the pharmacy and Director of Nursing on to complete a recapitulation. The DON in-serviced the 11-7 nurses on chart check procedure. A random audit of 3 residents on each will be completed on the first of the new month by the DON and ADON for accuracy of the recapitulation. 1. 4/24/09 The Director of Nursing will report the results of the audits to the Quality Assurance Team for review and recommendations. The quality assurance team will monitor for 3 month or until 100 % compliance is achieved.
3201.6.11.1.1	All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey report date completed 3/11/09, F333.	**Please cross reference Ftag 333 in the Federal 2567 for clarification**
3201.6.12	Communicable Diseases	
3201.6.12.2	Specific Requirements for Tuberculosis	
3201.6.12.2.3	All facilities shall have on file results of tuberculin tests performed on all newly admitted residents and newly hired employees, and annually thereafter on all employees. A tuberculin test as specified, done within the	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement. This requirement is not met as evidenced by:	
3201.6.12.2.6	Persons who do not have a significant reaction to the initial tuberculin test shall be retested within 7-21 days to identify those who demonstrate delayed reactions. Initial tests done within one year of a previous test need not be repeated in 7-21 days. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 3/11/09, F441 examples #1 through #5.	Please cross reference Ftag 441 in the Federal 2567 for clarification
3201.7.0	Plant, Equipment and Physical Environment	
3201.7.3.1	Water Supply and Sewage Disposal	
3201.7.3.1.2	The water system shall supply hot and cold	

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DATE SURVEY COMPLETED: 3-11-09

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	water under sufficient pressure to satisfy facility needs at peak demand.	
3201.7.3.1.3	Hot water accessible to residents shall not exceed 110° F.	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 3/11/09, F323 example #1.	**Please cross reference Ftag 323 in the Federal 2567 for clarification**
3201.7.5	Kitchen and Food Storage Areas	
3201.7.5.1	Facilities shall comply with the Delaware Food Code.	1. Non applicable since this did not affect a specific resident.
	This requirement is not met as evidenced by:	2. Non applicable since this did not have an direct affect on residents.
	Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 4-501.11, 4-601.11, 4-903.11, 6-301.12, and 6-501.114 of the State of Delaware Food Code. Findings include:	3. The ice was removed from the area. The door closure of the freezer and walk in cooler are being assessed if they are function effectively. The dietary staff are being in-serviced by the Food Service Director and or designee on the freezer being free of frozen condensation and how to report any maintenance issues. 4. The Food Service Director will complete random rounds of all refrigerated units and monitor the temperature log which also indicates any problems with the equipment on a daily basis. Any maintenance issues will be reported to the Administrator and Maintenance. The Food Service Director will report any problems and corrective measures taken to Quality Assurance Team to review and make recommendations. The quality assurance team will monitor for 3 month or until 100 % compliance is achieved.
	4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.	

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	This requirement is not met as evidenced by: Based on observations of the kitchen and staff interviews, it was determined that the facility failed to maintain the walk-in freezer in proper condition to eliminate leaks which has the potential of contaminating food. Observation of the kitchen walk-in freezer on 3/4/09 revealed frost on the ceiling and the floor of the freezer creating a safety hazard to the staff. Staff interview confirmed this finding. 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.* (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. This requirement is not met as evidenced by:	**4-601.11 Equipment, Food-Contact Services, Nonfood-Contact Surfaces and Utensils.** 1. Non applicable since this did not affect a specific resident. 2. All residents had the potential risk of being affected the following action was taken: 3. The dietary staff are going to be in-serviced on the procedure for pots and pan cleaning and air drying. The Life Enrichment Department will be in-serviced on proper cleaning of the oven located in the Activity Department. 4. The Food Service Director will conduct weekly sanitation rounds and will report any problems and corrective measures taken to Quality Assurance Team to review and make recommendations. The quality assurance team will monitor for 3 month or until 100 % compliance is achieved.

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	Based on observations of the kitchen and staff interviews, it was determined that the facility failed to maintain clean food contact and non-food contact surfaces. 1. On 3/4/09, encrusted grease and/or food debris was observed on the following kitchen equipment: a. food/nonfood contact surfaces of 11 of 13 hotel pans. b. food and nonfood contact areas of 4 of 4 meat loaf pans. c. non-food contact areas of two (2) frying pans stored on the ready-to-use rack. d. food and nonfood contact area of three sauce pots in the clean rack overhead above the sink. e. nonfood contact of 1 of 18 coffee cups. f. nonfood contact of ten (10) of ten (10) cookie sheets. g. inside the garland convection oven. 2. Observation of the activity room oven on 3/4/09 revealed the surfaces of the oven burners and inside floor was dirty. Staff interviews confirmed these findings. **4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.**	**4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.** **1. Non applicable since this did not affect a specific resident.** **2. All residents had the potential risk of being affected and all of the hotel pans were immediately removed from circulation until they could be rewashed.** **3. The dietary staff are being in-serviced by the Food Service Director and or designee on the proper procedure for air drying pots and pans. The Food Service Director will conduct weekly sanitation rounds.** **4. The Food Service Director will conduct weekly sanitation rounds and will report any problems and corrective measures taken to Quality Assurance Team to review and make recommendations. The quality assurance team will monitor for 3 month or until 100 % compliance is achieved.**

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	(B) Clean EQUIPMENT and UTENSILS shall be stored as specified under ¶ (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. This requirement is not met as evidenced by: Based on observations of the kitchen, it was determined that the facility failed to air dry kitchen equipment and stacked the items wet. On 3/4/09, eleven (11) out of thirteen (13) hotel pans and ten (10) out of ten (10) hotel pans were stacked wet on the ready-to-use storage rack. 6-301.12 Hand Drying Provision. Each handwashing lavatory or group of adjacent lavatories shall be provided with: (A) Individual, disposable towels; (B) A continuous towel system that supplies the user with a clean towel; or (C) A heated-air hand drying device. This requirement is not met as evidenced by:	**6-301.12 Hand Drying Provision** 1. **Non applicable since this did not affect a specific resident.** 2. **All residents had the potential risk of being affected and all of the towel dispensers were filled immediately.** 3. **The dietary staff are being in-serviced by the Food Service Director and or designee on the proper procedure for hand washing. The dietary department has an emergency supply of paper towels. The Food Service Director will conduct weekly sanitation rounds.** 4. **The Food Service Director will conduct weekly sanitation rounds and will report any problems and corrective measures taken to Quality Assurance Team to review and make recommendations. The quality assurance team will monitor for 3 month or until 100 % compliance is achieved.**

DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

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STATE SURVEY REPORT

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	Based on observations of the kitchen and staff interviews, it was determined that the facility failed to provide disposable towels for one (1) of two (2) lavatories in the kitchen. Observation of the two kitchen staff hand sinks on 3/4/09 at 8:35 AM revealed no hand towels in one (1) of the two (2) paper towel dispensers. Dietary staff interview confirmed this finding. **6-501.114 Maintaining Premises, Unnecessary Items and Litter.** **The PREMISES shall be free of:** **(B) Litter.** **This requirement is not met as evidenced by:** Based on observations of the kitchen, it was determined that the facility failed to maintain the premises free of litter. On 3/4/09, the grate on the floor next to the coffee machine had debris and was dirty. Additionally, debris was observed on the floor behind the ice machine of the kitchen.	**3201.7.6 Sanitation and Laundry** **3201.7.6.1 The facility shall provide for the safe storage of materials, pesticides and other potentially toxic materials.** 1. The hot was valve was adjusted correct the hot water temperature for resident rooms 107, 102, 211. a. The treatment cart on the 500 hall was immediately locked. b. The 400 hall janitor's closet was fixed. c. The commode legs were immediately adjusted. d. Mattress extensions were placed on the mattress in room 207 and 308B. e. Oxygen tank was immediately removed from the beauty shop. 2. An audit will be completed on the gap between the mattress and headboard. The residents and staff have been in-serviced on that oxygen can not be utilized in the beauty shop. 3. The environmental services department will be in-serviced by the Director of Environmental Services on keeping chemical locked both in the closet and on the carts. The facility staff and residents have been in-serviced about oxygen not being able to be utilized in the beauty shop. A sign has been placed in the beauty shop posting 'Oxygen not able to be used in this room'. The nurse will be in-serviced on keeping treatment and medication carts locked at all times when not in use by the Staff Development Coordinator. The maintenance department will be in-serviced by the Administrator about maintaining the water temperature for between 100 and 110 degrees. The department heads complete daily CQI rounds the mattress gaps will be added to the rounds for monitoring. The maintenance director and or designee will monitor water temperatures on a daily basis. The DON and ADON will complete random rounds on Treatment and Medication carts to validate that they are locked. The Environmental Services Director will complete random rounds validating that the janitor closet and carts are locked and in proper working order. 4. The DON will report the results of the random rounds related to the medication and treatment carts being locked to the Quality Assurance Team. The maintenance director will report results of the temperature monitor to the Quality Assurance Team. The Environmental Services Director will report results the chemicals being locked to the Quality Assurance Team. The quality assurance team will monitor for 3 month or until 100 % compliance is achieved.
3201.7.6 3201.7.6.1	**Sanitation and Laundry** **The facility shall provide for the safe storage of**	

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	Based on observations of the kitchen and staff interviews, it was determined that the facility failed to provide disposable towels for one (1) of two (2) lavatories in the kitchen. Observation of the two kitchen staff hand sinks on 3/4/09 at 8:35 AM revealed no hand towels in one (1) of the two (2) paper towel dispensers. Dietary staff interview confirmed this finding. 6-501.114 Maintaining Premises, Unnecessary Items and Litter. The PREMISES shall be free of: (B) Litter. This requirement is not met as evidenced by: Based on observations of the kitchen, it was determined that the facility failed to maintain the premises free of litter. On 3/4/09, the grate on the floor next to the coffee machine had debris and was dirty. Additionally, debris was observed on the floor behind the ice machine of the kitchen.	**6-501.114 Maintain Premise, Unnecessary Items and Litter:** 1. Non applicable since this did not affect a specific resident. 2. All residents had the potential risk of being affected by this practice. 3. The dietary staff are being in-serviced by the Food Service Director and or designee on the proper procedure floor sanitation. The Food Service Director will conduct weekly sanitation rounds. 4. The Food Service Director will conduct weekly sanitation rounds and will report any problems and corrective measures taken to Quality Assurance Team to review and make recommendations. The quality assurance team will monitor for 3 month or until 100 % compliance is achieved.
3201.7.6 3201.7.6.1	Sanitation and Laundry The facility shall provide for the safe storage of	

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	cleaning materials, pesticides and other potentially toxic materials. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey report date completed 3/11/09, F323 example #3. 16 Delaware Code, Chapter 11, Sub Chapter II It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following: §1121 Patient's Rights (1) Every patient and resident shall have the right	Please cross reference F tag 323 in the Federal 2567 for clarification for Example #3

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	to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 3/11/09, F164. 16 Delaware Code, Chapter 11, Sub Chapter II §1121 Patient's Rights (8) Every patient and resident shall receive from the administrator or staff of the facility a courteous, timely and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the patient or resident. This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey report date	**Please cross reference F Tag 164 in Federal 2567 for clarification**

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	completed 3/11/09, F166. **16 Del. C., 1162 Nursing Staffing:** (c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. Nursing staff must be distributed in order to meet the following minimum shift ratios (per Phase Two): RN/LPN CNA* Day 1 nurse per 15 residents 1 aide per 8 residents Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAIT serving as a CNA. As part of the DLTCRP survey, staffing for the periods of 1 through 21 February 2009 inclusive, and 28 September through 4 October 2008, were reviewed to verify compliance with Delaware	**16 Del C., 1162 Nursing Staffing** **Staffing** **1. Non Applicable** **2. Non Applicable** **3. The staffing coordinator is reviewing The staffing with the DON and ADON on A daily basis. The PPD is monitored by The NHA on a daily basis. If exigent Circumstances exist the facility will Utilize DON, Staff Development Coordinator and or RNAC to meet State Requirement 4/29/09** **4. Any non compliance will be reported to the Quality Assurance Team for review And recommendations by the DON. The QA team will monitor for 3 months Or until 100% compliance is achieved.**

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	Nursing Home Staffing Laws, commonly known as Eagles' Law. The citation hereon results from that work. **The law was not met as evidenced by:** Arbors failed to meet the required 3.28 Daily Care Hours per Resident on **ONE (1)** day. The care hours per resident attained by the facility on that day are parenthesed. 1. Saturday, 4 October 2009 (3.21).	